STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255252	A. BUILDING _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF GREENVILLE	1221 EAST UNION STREET GREENVILLE, MS 38703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 2/3/25 through 2/5/25. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F578 for advance directive and F641 for accuracy of assessment. The census at the time of the survey was 70 with a bed capacity of 90 beds.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still	F 578		3/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/26/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	Continued From page 1 legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record reviews, and facility policy reviews, the facility failed to honor a resident's rights to make her own healthcare decisions for end-of-life care for one (1) of 24 residents reviewed for advanced directives. Resident #3 Findings include: Record review of the facility policy titled, "Advance Directives" with a revision date of 9/2022 revealed The resident has the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. ...Facility will inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment at the resident's option and to formulate an Advanced Directive." Record review of the "Physician Statement of	F 578	1. Address how corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice; "Resident #3 Advanced directive was reviewed and signed by resident with corrections at residents request 2/12/25 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice; "All residents have potential to be affected by stated deficiency; Residents with BIMS of 10 or greater or deemed competent have been audited by the Admissions Nurse and their Advance directives signed by residents with corrections if requested on 2/12/25 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The policy on Request/reuse/discontinue treatment: Formulate Advance Directive was	

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F 578	Continued From page 2 Status of Mental Capacity of Resident" dated 1/23/24 revealed that the physician checked "Competent," revealing that the resident was able to make her own decisions. Record review of the "DNR (Do Not Resuscitate)/Full Code Request and Consent" form dated 1/23/24 revealed Resident #3 had not signed her consent form and that it was signed by a family member. In an interview on 2/04/25 at 3:00 PM, Resident #3 revealed she could make her own decisions, and when she was admitted to the facility, no one talked with her about her end-of-life wishes. She revealed her niece had already signed all the paperwork and she did not sign her own Advance Directive. She stated, "I had my legs cut off, not my brain," and revealed no one had gone over the paperwork with her. An interview on 2/04/25 at 3:31 PM, with the Admission Nurse revealed that she met with the family and had the paperwork signed prior to the resident's admission. She revealed that their physician also sees the resident prior to admission and deems the resident competent or non-competent in determining whether they can sign their own paperwork. She revealed Resident #3 was deemed competent; however, the niece signed the Advance Directive instead of the resident. She revealed that Resident #3 was able to make her own decisions and should have been given the opportunity to make her own decisions regarding her Advance Directive. An interview on 2/05/25 at 9:40 AM, the Administrator revealed that if a resident is able and competent to sign their own advance	F 578	reviewed by Administrator with Admissions Nurse on 2/6/25 and no revisions were necessary. "Facility will continue to include residents deemed competent or with BIMS over 10 in the admissions process and during their care plan conference on advance directives. Advance directives will be discussed weekly during care plan meetings with resident and change as resident requests 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system." Audits started on 2/18/2025 and will be conducted weekly x 4 weeks during care plan then 2 times a month for 3 months by Admissions nurse or Social department. Findings will be reported at QAPI on March 14, 2025 followed by monthly meetings for 3 months and the need for continued audits will be determined based on findings. 5. Indicate the date(s) the corrective action(s) will be completed Survey March 17, 2025	

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F 578	Continued From page 3 directive, the facility should go over the paperwork with the resident and allow them to sign. Record review of the Admission Record revealed Resident #3 was admitted to the facility on 01/23/2024 with medical diagnoses that included Hypertensive Heart Disease with Heart Failure, Cerebral Infarction, Acquired absence of right leg below the knee, and Acquired absence of left leg above the knee. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/6/25, revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #3 was cognitively intact.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately complete Section A of the Minimum Data Set (MDS) for a resident with a serious mental illness (SMI) for one (1) of 21 MDS reviewed. Resident #23 Findings Include: Review of the facility policy titled "Accuracy of Assessments" unrevised revealed, "The facility must ensure the assessment represents	F 641	1) Address how corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice; 1-Resident #23s Minimum Data Set assessment was modified to reflect the correct PASRR on 2/6/25 submitted and accepted on 2/26/25. 2- Address how the facility will identify other residents having the potential to be affected by the same deficient practice; "All residents have potential to be affected by stated deficiency; All residents	3/17/25

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F 641	Continued From page 4 accurately the resident's status during the observation/look back period. The assessment must be reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline." Record review of the Preadmission Screening and Resident Review (PASRR) "Summary of Findings Report" dated 11/02/16 revealed under, "Mental Health: The individual meets criteria for having a diagnosis of mental illness as defined by PASRR." Also revealed under, "Axis I primary" a diagnosis of "Schizophrenia, paranoid type" and under, "Axis I secondary" a diagnosis of "Psychotic disorder." Record review of the Annual MDS with an Assessment Reference Date (ARD) of 4/18/24, revealed under, section A1500, "Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition?" No was marked. An interview with the MDS Nurse on 2/04/25 at 3:10 PM confirmed, Resident #23 had a SMI and revealed the MDS was not coded correctly. She explained that she kept a list of the residents that had a Level II but must have overlooked it. The MDS Nurse revealed the purpose of having an accurate assessment was for the staff to provide the best possible care for the residents. An interview with the Administrator on 2/5/25 at 11:36 AM, revealed her expectations were for the MDS to be checked and submitted accurately, so the residents get the best quality of care for	F 641	requiring a PASRR requiring level two. The Minimum Data Set nurse audited all of the MDS for all residents requiring a level II PASSR to assure accuracy of coding on 2/6/2025. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; on 2/6/25 the policy on Accuracy of Assessments was reviewed by Administrator and Minimum Data Set staff with no revisions necessary. MDS Nurse made corrections to accurately reflect the residents' status starting on 2/6/25. On admission a Notice of New Admission form will be filled out by admissions nurse and given to MDS staff to indicate whether or not resident requires a level II. An audit was conducted of all residents and Incorrect assessments were modified that require a PASSR 4- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. MDS Nurse or MDS department will audit 100% of completed assessments weekly starting on 2/12/2025 for PASRR level accuracy for 4 weeks and then monthly x 3 months to ensure accuracy. Findings will be reported at QAPI on March 14, 2025 followed by monthly meetings for 3 months and the need for continued audits will be determined based on findings.	

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F 641	Continued From page 5 mental health. Record review of the "Admission Record" revealed the facility admitted Resident #23 on 10/12/16 with medical diagnoses that included Paranoid Schizophrenia, Unspecified Psychosis and Hallucinations.	F 641	5. Indicate the date(s) the corrective action(s) will be completed Survey March 17, 2025	